BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Anne Arundel Co.
(b) Street address 3 6" ave Brooklyn Pk.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 03588
(c) City or town Brooklyn Park Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 - 6" Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary P. Basford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Russell D. Basford
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 5 - 1 - 1867

8. AGE: Years	Months	Days	If less than one day
80		20	hr. min.

9. Birthplace Calvert County Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Upon Home

FATHER
12. Name John Darnell
13. Birthplace St. Michaels Md

MOTHER
14. Maiden Name Sarah M. Cummings
15. Birthplace St. Michaels Md.

16 (a) Informant Mrs. Ralph Nelson
(b) Address 205 E. Chula St. Brooklyn Pk. Balto Md

17 (a) Buried (b) Date thereof 5 - 24 - 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lishmans Pt.
Location Leightons Talbot Co. Md

18 (a) Funeral director Thomas Mitchell
(b) Address St. Michaels Md.

19 (a) 5/22 (b) 47 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21, 1947, to May 21 1947, and that I last saw h alive on May 20 1947.

	Duration
Immediate cause of death Cerebral Hemmorhage	3 da
Antecedent Pneumonia	1 years
Due to Arteriosclerosis C.V.D.	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury
23. Signature Paul E. Lyon M. D.
Address 2201 Argyle Date signed 5/24/47

VS 150

VS A15 9-45-15M

Evidence for change of birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 110 JUN 3 1947 **CERTIFICATE OF DEATH**

97 P

03582 23

Reg. Dist. No.

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town RURAL-GLEN BURNIE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 YRS

Hospital, Institution, or street address where death occurred: POINT PLEASANT

How long in hospital or institution? NOT HOSPITALIZED

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDEL

City or town RURAL-PT PLEASANT

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOHN CHARLES SOMMERS (BOKONICK-)

3.(b) Social Security Number NINE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	~~MARRIED~~ WIDOWER

6.(b) Name of husband or wife ELIZABETH SOMMERS

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 22, ~~1867~~ 1869

8. AGE:	Years	Months	Days	If less than one day
	78	1	3	hrs. min.

9. Birthplace AUSTRIA (Town, county, and state)

10. Usual occupation BLACKSMITH

11. Industry or business STATE ROAD COMM.

FATHER 12. Name JOHN BOKONIK

FATHER 13. Birthplace AUSTRIA

MOTHER 14. Maiden name UNKNOWN

MOTHER 15. Birthplace AUSTRIA

16. Informant MRS. EMMA BRANNOCK

Address POINT PLEASANT.

17. Burial (Burial, cremation, or removal. Which?) Date thereof MAY 28-47 (month) (day) (year)

Cemetery or crematory CEDAR HILL CEM.

Location A.A.Co

18. Funeral director Bernard C. Harle

Address 121 E West St

19. 5/26 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 19 47 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOT ATTENDED 19 to 19

and that I last saw him alive on NOT SEEN 19

Immediate cause of death ACUTE CARDIAC FAILURE — DURATION

Due to HYPERTENSION AND ARTERIOSCLEROSIS

Due to UNKNOWN

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry J. Bourgeois M.D. M. D. or other

Address Glen Burnie Md Date signed 5-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97 03590

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Rural) Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ShadySide

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Allie Brisco

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Martha Briscoe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): I882

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Shady Side, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Wegie Brisco

13. Birthplace: Md.

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Martha Brisco

Address: Shady Side, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1947 (month) (day) (year)

Cemetery or crematory: St Matthews

Location: Shady Side, Md.

18. Funeral director: J.B.Johnson

Address: Annapolis, Md.

19. June 1, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947, at 6 11 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 30 1947, to May 30 1947 and that I last saw h. l7 alive on May 30 1947

	DURATION
Immediate cause of death: Coronary Failure	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address Date signed May 31, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03591

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 years, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 929 Myrtle Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Olive Briscoe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: William Briscoe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 years (1923)

8. AGE: Years	Months	Days	If less than one day
24			hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: John Daneron
13. Birthplace: Virginia

MOTHER
14. Maiden name: Salome Wright
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. BURIED (Burial, cremation, or removal. Which?) Date thereof: May 24, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Maryland

18. Funeral director: Katie L. Williams

Address: 320 N. Schroeder

19. 5-27-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 19 47, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1943, 19, to May 20, 19 47, and that I last saw her alive on May 20, 19 47

Immediate cause of death: Lung Tuberculosis — DURATION: since April 7, 47

Due to:

Due to:

Other conditions: Dementia Praecox, Paranoid Type
(Include pregnancy within 3 months of death)

Major findings of operations: Known to us since

Date of op. May 9, 43

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 5-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1200

03592

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, institution, or street address where death occurred:
104 Calvert St. Annapolis Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 104 Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: XXXXXXXXXXXXXXXXXXXXXXXX

3.(a) FULL NAME: Helen Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife: XXXXXXXXXXXXXXXXXXXXXXXX
6.(c) If alive, give age: XXXXX years

7. Birth date of deceased (mo., day, yr.): September 9, 1910

8. AGE: Years 36 | Months 8 | Days | If less than one day: hrs. min.

9. Birthplace: Annapolis Anne Arundel Co. Md. (Town, county, and state)

10. Usual occupation: Maid work

11. Industry or business: None

FATHER
12. Name: William Brown
13. Birthplace: West River Md.

MOTHER
14. Maiden name: Agnes Brooks
15. Birthplace: West River

16. Informant: Mrs Agnes Brown
Address: 104 Calvert St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/47 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Chas. E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 22, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947, at 8 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1947 to 5-19 1947 and that I last saw h[illegible] alive on 5-17 1947

Immediate cause of death	DURATION
Gastro-enteritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M.D. M. D. or other
Address: 17 Carroll St. Date signed 5-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122B

03593

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) —
2.(a) If veteran, name war

3.(a) FULL NAME Martha Ann Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Married

6.(b) Name of husband or wife: Mack Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 10. 1877

8. AGE:

Years	Months	Days	If less than one day
70	5	—	hrs. ... min.

9. Birthplace: Galesville Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Danl Davis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Martha Davis
15. Birthplace: Galesville Md

16. Interment: Mack Brown
Address: Cumberstone
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1947 (month) (day) (year)
Cemetery or crematory: Galesville Mem.
Location: Galesville Md
18. Funeral director: J. A. Standiford & Son
Address: Galesville Md.
19. May 13 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947, at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 1947, to 10 May 1947, and that I last saw h... alive on 10 May 1947.

	DURATION
Immediate cause of death: Intestinal obstruction, acute,	10 days
due to, or as a consequence of: adhesions	
Due to: [illegible] performed approx. 30 yrs ago at Johns Hopkins Hospital	
Due to:	
Other conditions: Arteriosclerotic heart disease - auricular fibrillation (Include pregnancy within 3 months of death)	several years

Major findings of operation: adhesion causing a Duodenum. Date of op. 10 May 47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dewey H. Hukes M.D. M. D. or other
Address: 53 Cornhill St Date signed: 13 May 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

03594

Reg. Diat. No. 28

1. PLACE OF DEATH:

County ~~St. Mary's~~ Anne Arundel

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Maryland

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Pearson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Louis Chapman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife ~~xxxx~~ Mrs. Charles L. Chapman

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) unknown Jan 7, 1879

8. AGE: Years	Months	Days	If less than one day
about 68	?	?	...hrs. ...min.

9. Birthplace unknown Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name George Chapman

13. Birthplace Maryland.

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant Hospital Records

Address Crownsville State Hospital, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 6/22/47 (month) (day) (year)

Cemetery or crematory Holy Face

Location Great Mills

18. Funeral director P B Robinson

Address Leonardtown Md.

19. 5/21/1947 (Date rec'd by registrar) Canalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 47 at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 47, to May 19 19 47 and that I last saw him alive on May 19 19 47

Immediate cause of death Cerebral Arteriosclerosis DURATION

Known to us since May 3, 1947

Due to

Due to

Other conditions Senile Psychosis Known to us since May 3, 1947

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob Morgenstern M. D. M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of birthdate shown on:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03595

83a

FILM No. G 11 C JUN 6 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 58 State Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lucy C. B. Claude
3.(b) Social Security Number

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): ~~January~~ July 3d 1865
8. AGE: Years 82 Months 10 Days 24 If less than one day ... hrs. ... min.
9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Abram Claude
13. Birthplace: Annapolis Md

MOTHER
14. Maiden name: Rachel Tuck
15. Birthplace: Annapolis Md.

16. Informant: W. Halem Claude
Address: Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29-47 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. May 29 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947, to May 27 1947
and that I last saw her alive on May 27 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	april 1
Due to: Hypertension	unknown
Due to:	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: George C Brown M. D. or other
Address: Annapolis Md Date signed: 5-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

03596

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mayo Vista - P.O. Arnold, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3 years.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. Jennie Colburn

3.(b) Social Security Number:

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Henry V. Colburn
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): March 16 - 1889
8. AGE: Years: 58 Months: 1 Days: 25 If less than one day: hrs. min.
9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Eugene Golden
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Jennie Farmer
15. Birthplace: A A Co Md
16. Informant: Mrs. John Colburn
Address: Mayo Vista, P.O. Arnold
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14th 1947 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. May 14, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1947, at 4 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1947, to May 11 1947 and that I last saw h.e.r. alive on 5/11/47 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hr.
Due to: Hypertension	?
Due to: senelity	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Faulbert M.D. M. D. or other
Address: Glen Burnie Md. Date signed: 5/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

03597

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Emergency Hosp.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Parole Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: South River Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Cromite

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	widow

6.(b) Name of husband or wife: Widower

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1881 —

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	—	—		

9. Birthplace: West River, Lothian Md. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: None

FATHER 12. Name: Alexander Pratt

FATHER 13. Birthplace: Lothian, West River

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Eugene Thomas

Address: Parole

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-6-1947 (month) (day) (year)

Cemetery or crematory: Fowlers Chapel

Location: West Gate Road

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. May 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1947, at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that ~~accompanied~~ Post mortem & Examination ~~attended~~ ~~examined~~ May 3, 1947

Immediate cause of death	DURATION
Fracture of Skull	
Due to (automobile accident)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5/1/47

Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): College Rd.

Means of injury: Hit by automobile Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md. Date signed: 5/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03598 B

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 1 day

Hospital, Institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 3 months 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 128 S. High Street (If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Henry F. Croner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Susie P.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1904

8. AGE: Years	Months	Days	If less than one day
42 yrs.	11	27	– hrs. ------ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER — 12. Name: Anderson Croner

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Betty Whaller

MOTHER — 15. Birthplace: Virginia

16. Informant: Hospital Records, Crownsville State Hospital

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof: May 18, 1947 (month) (day) (year)

Cemetery or crematory: Family Lot

Location: Pamplin, Va

18. Funeral director: Mr. George H. Holland

Address: 163rd Druid Hill Ave

19. May 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1947 1947, at 10:50 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 11 1947 to May 12 1947 and that I last saw him alive on May 12 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 2-11-47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Baumgarten M. D. (M. D. or other)

Address: Crownsville, Maryland Date signed: 5-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 0359 26

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? at Home

Hospital, institution, or street address where death occurred: at Home

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A A Co.

City or town: Linthicum
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 S. Hammonds Ferry Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Minnie Denty Cross

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female / Male	White	Widow

6.(b) Name of husband or wife: Charles A. Cross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	4	..... hrs. ..... min.

9. Birthplace: Balto Md
(Town, county, and state)

10. Usual occupation: none

11. Indusfry or business: none

FATHER
12. Name: Henry H Denty
13. Birthplace: Balto Md

MOTHER
14. Maiden name: Elizabeth A. Stuart
15. Birthplace: Balto Md.

16. Informant: Mrs Eleanor C. Fisher (daughter)

Address: 106 S. Hammond Ferry Rd.

17. Burial, cremation, or removal. Which?: Burial Date thereof: May 9 47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: A A Co. Md.

18. Funeral director: Stewart Mortuary Co.

Address: 108 W Mort - Balto Md

19. 5-9 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (May) May 7 1947, at 4 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 20 1947, to May 7 1947 and that I last saw h.er alive on May 6 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to Chronic Myocarditis	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exfernal causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, indusfry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: N. Franklin M. D. or other

Address: 1123 St Paul St Date signed .....

Funeral Director 'phoned that deceased was "female". DM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03600

183

CB

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: South River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Dist. of Columbia County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 769 Quebec Pl. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Glenn Gordon Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 7th 1926

8. AGE:

Years	Months	Days	If less than one day
20	5	23	hrs. min.

9. Birthplace: Columbus Ohio (Town, county, and state)
10. Usual occupation: Employed by
11. Industry or business: Washington Gas Co.

FATHER
12. Name: Glenn Gordon Davis
13. Birthplace: Indiana

MOTHER
14. Maiden name: Harriett L. Williams
15. Birthplace: Va.

16. Informant: Mrs Harriett M. Barlow
Address: 769 Quebec Place Washington D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof June 12 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Martin W. Hyson Co
Address: Washington D.C.
19. June 1 19 47 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947 at 2 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~at the hour stated above~~
Post mortem Examination
and that I last saw ~~him~~ alive on June 1 1947
Immediate cause of death: Drowning — DURATION

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of injury: 5/30/47
Where did injury occur? near Edgewater (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): South River
Means of injury: drowning Injured at work? No
23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis Md. Date signed: 6/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03601

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years 2 months 27 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 3 years 2 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 S. Bantz
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Pauline Dean

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Negro	single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 1904 --

8. AGE: 43 Years | Months: ? | Days: ? | If less than one day: ---hrs.--- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: --

FATHER
12. Name: Waver Dean
13. Birthplace: Maryland

MOTHER
14. Maiden name: Fanny Thomas
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. BURIED (Burial, cremation, or removal. Which?) Date thereof: May 30,1947 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Frederick, Maryland

18. Funeral director: Atchison & Son
Address: Frederick, Maryland

19. May 29 1947 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1944 to May 29 1947 and that I last saw her alive on May 29 1947

Immediate cause of death	DURATION
General Paresis	Known to us since March 2,1944
Due to: Syphilis	Known to us since March 2,1944
Due to:	
Other conditions: Pulmonary Tuberculosis	Known to us since 1/6/47

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D. M. D. or other
Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the approx. age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

03602

Reg. Dist. No.

FILM No. G 110 JUN 27 1947

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A Co
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Floyd Dischen

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Unknown

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62 to 65				

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace "

MOTHER
14. Maiden name: Unknown
15. Birthplace "

16. Informant: County Home Records
Address: Edgewater Md

17. Burial, cremation, or removal. Which?: Burial
Date thereof: May 26 1947 (month) (day) (year)
Cemetery or crematory: County Home Plot
Location: Edgewater Md

18. Funeral director: D. C. Hardesty & Son
Address: Oakwood Md

19. (Date rec'd by registrar): May 26 1947
Registrar: Edward Collmus

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1947, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1947 to May 25 1947
and that I last saw h. alive on May 23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M K Lavans Md
M. D. or other
Address: 31 Sutton Ave Date signed: 5/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03603

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A.A.

City or town: Annapolis, Neck. Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 89 Years

Hospital, institution, or street address where death occurred:
Annapolis, Neck

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis, Neck.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louis L. Duvall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept II 1857

8. AGE:

Years	Months	Days	If less than one day
89	7	4	..... hrs. ..... min.

9. Birthplace: A.A. County
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: Samual E. Duvall
13. Birthplace: Maryland

MOTHER
14. Maiden name: Adaline E. Slemaker
15. Birthplace: Maryland

16. Informant: E. Saunders Duvall

Address: 107 Monticlio Ave. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1947 (month) (day) (year)

Cemetery or crematory: Salem

Location: Annapolis, Neck.

18. Funeral director: B.L. Hopping & Son

Address: Annapolis, Md.

19. May 17, 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 47 at 5 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1947, to May 15, 1947

and that I last saw h... alive on May 15, 1947

Immediate cause of death	DURATION
Pulmonary Edema	4 days
Due to: Chronic Myocarditis	3 Yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. Martin, M.D.
M.D. or other

Address: 165 Prince George St. Annapolis, Md. Date signed 5/16/47

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

03605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: ~~Baltimore~~ Anne Arundel
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Roland and Arbutus Roads, Section 23
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: ~~Baltimore~~ A.A.
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Roland and Arbutus Roads, Section 23
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ruth May Fertitta

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Fertitta
6.(c) If alive, give age: 41 years
7. Birth date of deceased (mo., day, yr.): May 23, 1910

8. AGE: Years	Months	Days	If less than one day
36	11	19	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harry Doell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lula Rowley
15. Birthplace: Maryland

16. Informant: Mr. Joseph Fertitta
Address: 4003 Woodridge Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.
18. Funeral director: Miller & Lamorgan
Address: 1003 W. Baltimore St.

19. May 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947 at 10.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-1-47 1947 to May 12 1947
and that I last saw her alive on May 11-47 1947

	DURATION
Immediate cause of death: Generalized Adeno carcinomatosis	3 mos.
Primary site: Systemic Flex of colon	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Generalized Carcinomatosis Date of op. 4-1-47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Medical Arts Bldg. Date signed May 12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03604

Reg. Diat. No. 24

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 28 College Ave.

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 28 College Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: Margret Ellen Edwards

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Johnnie Dee Edwards

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): September 8, 1923

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
23	8	5		

9. Birthplace: Annapolis, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: James Thomas Brown

13. Birthplace: St. Marys Co.

MOTHER

14. Maiden name: Mary F. Plummer

15. Birthplace: Prince George Co.

16. Informant: Cecilia Green

Address: 28 College Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-16-1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. May 16, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1947, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1947, to May 13, 1947 and that I last saw h.. alive on May 13, 1947

Immediate cause of death		OURATION
	Pulmonary Hemorrhage	2 hr.
Due to	Pulmonary Tuberculosis	—
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Theodore R. Johnson M.D. M. D. or other

Address: 40 Northwest Street Date signed: 5/15/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92b

C3606

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 18 days
Hospital, institution, or street address where death occurred:
Crownsville, State Hospital, Crownsville, Md.
How long in hospital or institution? 1 month 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frank.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 102 W. North Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Edith Ford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Unknown 1898

8. AGE: 49 Years	Months	Days	If less than one day
Approximately	?	?	....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: —

FATHER
12. Name: Joe Ford
13. Birthplace: ?

MOTHER
14. Maiden name: Francis Bullett
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 19, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Maryland

18. Funeral director: Wm. H. Downey
Address: Hagerstown, Maryland

19. May 15 (Date rec'd by registrar) 1947 E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947 at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947, to May 14 1947
and that I last saw her alive on May 14 1947

Immediate cause of death	DURATION
Mitral Insufficiency Decompensated	Known to us
Due to	since 3-29-47
Due to	
Other conditions: Schizophrenia	Known to us
(Include pregnancy within 3 months of death)	since 3-29-47

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: May 15, '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03607

CERTIFICATE OF DEATH

Reg. Dist. No. 25T

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A A.

City or town: Brooklyn Park Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Seventh Ave - Zone 25

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Constance Elizabeth Foreman.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Josiah Hite Foreman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 11 - 1885

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hydman Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Hamilton W. Weller

13. Birthplace: Penn.

MOTHER 14. Maiden name: Laura Wertz

15. Birthplace: Penn.

16. Informant: Mr. Jesse E. Foreman

Address: 1428 L St S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Washington D.C.

18. Funeral director: Milton Schilling

Address: 3914 Hanover St - Zone 25 -

19. May 21 1947 (Date rec'd by registrar) Ida M. Ulrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 19 47 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 40 to May 20 19 47

and that I last saw h alive on May 20 19 47

Immediate cause of death	DURATION
Cerebral Haemorrhage	5-16-47
Due to	
Due to	
Other conditions Arteriosclerosis	5-6 yrs
Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

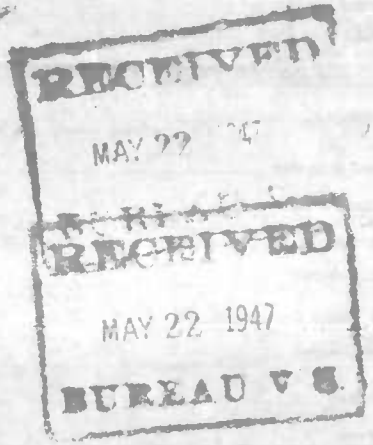
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Ball Jr MD M. D. or other

Address: Linthicum - Date signed 5-20-47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BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03608

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years 6 months

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 13 years, 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Churchtown (If outside city or town limits, write RURAL and give nearest town)

Street No.: / (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Fountain William T.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 14th, 1898

8. AGE: Years: 49 | Months: | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace:

16. Informant: Hospital records Address: Crownsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20th-47 (month) (day) (year)

Cemetery or crematory: Franklin Cem.

Location: Annapolis, Md.

18. Funeral director: H. T. Hardesty & Son

Address: Galesville, Md.

19. 5/18 1947 S. F. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17th 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1933, to May 17th 1947

and that I last saw him alive on May 17th 1947

Immediate cause of death: Tuberculosis Laryngitis Lungs

DURATION
Known since May 12th 47
Known since 1933

Due to:

Due to:

Other conditions: manic dept. psychosis

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D. M. D. or other

Address: Crownsville Date signed: 5-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03609

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town St Margarets

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carvel Hall

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ellen Tucker Gearing

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow.

6.(b) Name of husband or wife Henry C. Gearing

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany. 12th 1862

8. AGE: Years 85 Months 4 Days 3 If less than one day hrs. min.

9. Birthplace Portsmouth N. H.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John Tucker

13. Birthplace Portsmouth N. H.

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Lt Comdr Wallace Gearing U.S.N.

Address Alexandria Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19 1947 (month) (day) (year)

Cemetery or crematory Naval Cemetery

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. May 16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 3.20 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 20 1946 to May 10 1947 and that I last saw her alive on May 10 1947

	DURATION
Immediate cause of death	
Cerebral Apoplexy	sudden
Due to	
General Arterial Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Taylor M.D.

M. D. or other

Address Annapolis Md. Date signed 5/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 83a

03610

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Severn River
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth J. Gilbert

3.(b) Social Security Number

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Wm E. Gilbert.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept 15th 1863
8. AGE: Years 83 | Months 7 | Days 28 | If less than one day ... hrs. ... min.
9. Birthplace A A Co Md. (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name John E. Johnson
13. Birthplace A A Co Md.

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Jacob J. Fishell
Address 1707 N Milton St Balto Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14-1947 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Blvd A A Co Md.
18. Funeral director John M. Taylor Son
Address Annapolis Md.
19. May 14, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 4.15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1947, to May 12 1947 and that I last saw h... alive on May 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days.
Due to	
Due to	
Other conditions Operated 4/30 - Senile cataract	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE M. J. Klemm Md M. D. or other
Address 31 Southgate Ave Date signed 5/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 0361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County A.A. Maryland

City or town Annapolis.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? IO Years

Hospital, institution, or street address where death occurred:

I8I Gloucester Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County A.A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. I8I ~~Glouster~~ Gloucester

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frederick C. Gifford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widow

6.(b) Name of husband or wife Ada W. Gifford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~Mne~~ March I5 I863

8. AGE: Years	Months	Days	If less than one day
84	I	I7	..... hrs. ..... min.

9. Birthplace New York State (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Abner Gifford

FATHER 13. Birthplace New York State

MOTHER 14. Maiden name Eunice McComber

MOTHER 15. Birthplace New York State

16. Informant Mrs Irene G Lyons

Address I8I Gloucester St. Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 4 I947 (month) (day) (year)

Cemetery or crematory

Location Aurora New York State

18. Funeral director B.L.Hopping & Son

Address Annapolis, Md.

19. 5-4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to May 2 1947

and that I last saw h.. alive on May 2 1947

Immediate cause of death

Myocardial Chr

Myocardial Insufficiency

Due to

Due to

Other conditions Cerebral Sclerosis

DURATION: Several years; unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 5-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03612

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? pronounced dead on arrival
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Quarterfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: URSULA B. GOEDEKE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William J. Goedeke
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1887

8. AGE: Years	Months	Days	If less than one day
59	5	12	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own home
FATHER 12. Name: Frank Mackenrodt
13. Birthplace: Baltimore Maryland
MOTHER 14. Maiden name: Mary Stieffel
15. Birthplace: Baltimore Maryland
16. Informant: Rose Goedeke
Address: Quarterfield Road, Severn, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1947 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Glen Burnie, Md. R.F.D.
18. Funeral director: Thomas W. Dinkelacker
Address: Glen Burnie, Md.
19. May 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1947 at 10-15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~19~~ Postmortem Examination 19~~..~~; and that I last saw h~~im~~ alive on May 27 1947

Immediate cause of death	DURATION
Acute dilatation of Heart	sudden
Due to: Chronic myocarditis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930

03613

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 West

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Edward Graefe Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Margaret R. Graefe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 18th 1881

8. AGE: Years 66 Months 3 Days 20 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Retired Butcher

11. Industry or business Prop. Peoples Meat Market

FATHER 12. Name Herman C. Graefe

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant George E. Graefe Jr.

Address 1207 West St. Annapolis Md.

17. Burial Date thereof May 11th 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. May 11, 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 11 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1947, to May 8 1947 and that I last saw him alive on May 8 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 hr
Due to Arteriosclerosis	9 yrs
Due to Arterial Hypertension	2 yrs. Assumed
Other conditions	Unknown yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Oliver Parker M. D. or other

Address Annapolis Md. Date signed 5/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03614

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Bristol (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 6 Mos

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Md County: A. A

City or town: Bristol (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) 2

2.(a) If veteran, name war

3.(a) FULL NAME Ella Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widow

6.(b) Name of husband or wife: John T. Hall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 23 1858

8. AGE:

Years	Months	Days	If less than one day
88	4	26	hrs. ..... min.

9. Birthplace: Hall P.G. Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Francis Magruder Hall

13. Birthplace: Hall Md

MOTHER — 14. Maiden name: Rosalie Eugenia Carter

15. Birthplace: Hall Md

16. Informant: Jos Shaney Rd

Address: Bristol Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1947 (month) (day) (year)

Cemetery or crematory: Quaker Church

Location: Galesville Md

18. Funeral director: F. L. Haughey & Son

Address: Galesville Md

19. 5/24 1947 (Date rec'd by registrar) W. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 19 1947, and that I last saw h.e alive on May 15 1947

Immediate cause of death	DURATION
Cerebral hemmorhage	
Due to hypertension	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. M. D. or other

Address: Lothian, Md. Date signed 5/19/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13-b 03615 26 Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 744 W. Franklin (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: George Hamlin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown (deceased)
— 6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
52 ?	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: George ?
13. Birthplace: ?

MOTHER
14. Maiden name: Betty ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 21, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Maryland

18. Funeral director: Mrs. Katie L. Williams
Address: 322 N. Schroeder St. Baltimore, Md.

19. 5-21-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1947, at 9:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1947, to May 14, 1947 and that I last saw him alive on May 14, 1947

Immediate cause of death	DURATION
Lung tuberculosis	Known to us since April 14, 1947
Due to:	
Due to:	
Other conditions: Alcoholic Psychosis - Delirium Tremens	Known to us since April 14, 1947

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Mangerstein M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 5-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03616

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 2 months 23 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 yr. 2 months 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Timothy Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	?

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
47	?	?	hrs. min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business: -

FATHER
12. Name: --
13. Birthplace: -

MOTHER
14. Maiden name: --
15. Birthplace: -

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/7/47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: Ralph W. Bates

Address: Crownsville

19. May 7 1947 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1947 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1946 to May 2 1947

and that I last saw him alive on May 2 1947

Immediate cause of death: General Paresis — DURATION: Known to us since 2-9-46

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M.D. or other

Address: Crownsville, Maryland Date signed: 5-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1251

FDM No. G 110 JUN 16 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 036172

1. PLACE OF DEATH:

County A.A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:
14 College Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 College Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war ••••••••

3.(a) FULL NAME Mary Adams Haste

3.(b) Social Security Number ••••••••••••••

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widow

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1866

8. AGE: Years	Months	Days	If less than one day
~~81~~ 80	5	26	..... hrs. ..... min.

9. Birthplace Annapolis, Md.
(Town, county, and State)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Richard Harris

FATHER 13. Birthplace Annapolis, Md.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace "

16. Informant Richard Haste

Address 14 College Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/47 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location West Street Extend.

18. Funeral director Mrs. Chas. E. Hicks

Address 45 Northwest Street

19. May 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1947, to May 26 1947 and that I last saw h.. alive on May 26 1947

Immediate cause of death	DURATION
Hepatitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. T. Allen Jr M.D.

Address 17 Carroll St M. D. or other

Date signed 5-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75d

CERTIFICATE OF DEATH

03618

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: A.A.

County.....

City or town.....Weems Creek. West Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....8 Years

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland County.....A.A.

City or town.....Weems Creek Near West Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Charlotte E. Heckrotte

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife.....Thomas T. Heckrotte

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) July 2 1860

8. AGE: Years	Months	Days	If less than one day
86	10	25	.....hrs. .....min.

9. Birthplace.....Baltimore, County
(Town, county, and state)

10. Usual occupation.....None

11. Industry or business

FATHER 12. Name.....Jacob F. Cornes

13. Birthplace Baltimore, County

MOTHER 14. Maiden name.....Martha A. Walters

15. Birthplace Baltimore, County

16. Informant.....Frank B. Heckrotte

Address Weems Creek. Annapolis, R.F.D. #3

17.....Burial..... Date thereof.....May 30 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Loudon Park

Location.....Balto. Maryland.

18. Funeral director.....B.L.Hopping &son

Address Annapolis, Maryland.

19. May 29 19 47 .....Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 27 19 47, at 1 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19 47, to May 27 19 47 and that I last saw h.....alive on May 27 19 47

Immediate cause of death	DURATION
Myocarditis & Myocardial Degeneration	unknown
Due to	
Due to	
Other conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 5-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 03619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 44 J Severn Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Roy M. Horsman HORSMAN Horsman HORSMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Anna Horsman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 17 1893

8. AGE:

Years	Months	Days	If less than one day
53	8		hrs. min.

9. Birthplace: Salesbury (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Anna Horsman

Address: Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20 (month) (day) 1947 (year)

Cemetery or crematory: St Mary's

Location: Annapolis Md

18. Funeral director: John M. Taylor Co. Inc

Address: Annapolis Md.

19. May 19, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Compton, Md Date signed: 5/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03620

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 6 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland Cooty:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1620 Madison Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME

John Howard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): Unknown (1915)

8. AGE	Years	Months	Days	If less than one day
Approximately	32	-	-	hrs. - min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 22 1947 (mo.) (day) (year)

Cemetery or crematory: Mt. Calvery

Location: Anne Arundel County

18. Funeral director: Adolph Holstead

Address: 918 Druid Hill Ave., Baltimore, Md.

19. 5/21 1947 (Date rec'd by registrar) A. W. Hedrick Registrar JC

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 5 1947 to May 11 1947 and that I last saw him alive on May 11 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 4-5-47
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 5-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03621

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne-Arundel

City or town: Gambrills (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Indiana County: unknown

City or town: Anderson (If outside city or town limits, write RURAL and give nearest town)

Street No. [illegible] (If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME: Oliver Ernest Howard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Esther Howard 6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1883

8. AGE: Years	Months	Days	If less than one day
63	8	6	hrs. min.

9. Birthplace: Center District, Calvert Co. Md. (Town, county, and state)

10. Usual occupation: Contractor + Builder

11. Industry or business

FATHER

12. Name: William Howard

13. Birthplace: Alabama

MOTHER

14. Maiden name: Rachel Anne Robinson

15. Birthplace: Calvert Co Md.

16. Informant: Malcolm R Howard

Address: Gambrills Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 20/47 (month) (day) (year)

Cemetery or crematory:

Location: Anderson Ind.

18. Funeral director: H E Hopkins & Son

Address: Annapolis Md.

19. May 20 19 47 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 19 47, at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 47, to May 19 19 47 and that I last saw h...i...m...alive on May 19 19 47

Immediate cause of death	DURATION
Coronary Occlusion	2 Hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward J Otenasek M.D. M. D. or other

Address: Gambrills Md Date signed: May 19, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122b

CERTIFICATE OF DEATH

03622

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 219 Chesapeake Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Norman Jensen Jr.

3.(b) Social Security Number 217-24-2947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16th 1928

8. AGE:

Years	Months	Days	If less than one day
18	11	20	..... hrs. ..... min.

9. Birthplace: Eastport Md. (Town, county, and state)

10. Usual occupation: Clerk - Bank.

11. Industry or business: Annapolis Banking Trust Co.

FATHER

12. Name: John N. Jensen Sr.

13. Birthplace: Denmark

MOTHER

14. Maiden name: Ingeborg Munsfeldt

15. Birthplace: Denmark

16. Informant: John N. Jensen Jr.

Address: 219 Chesapeake Av. Eastport Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: May 8th (month) (day) 1947 (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. May 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1947 at 10:35 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 6 1947 to May 6 1947 and that I last saw h.. alive on May 6 1947

Immediate cause of death	DURATION
(a) intestinal obstruction (mechanical) stomach	2 days
Due to: (b) Congenital rectal stricture	8 yrs.
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirmed diagnosis above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: S. Bossuck. Md M. D. or other

Address: Annapolis Md. Date signed: 5/7/47

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 03623 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:
106 Calvert Street Annapolis Md.

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Calvert St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: George Washington Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: **********

6.(c) If alive, give age (**) years

7. Birth date of deceased (mo., day, yr.): June 12, 1894

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52				

9. Birthplace: Anne A undel Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Thomas Johnson
13. Birthplace: Anne Arundel Co, Lothian Md.

MOTHER
14. Maiden name: Deliah Watts
15. Birthplace: A. A, Co. Md. Lothian

16. Informant: Mrs Florence Brown
Address: 106 Calver t St. Annapolis Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: May 15, 1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West St. extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. (Date rec'd by registrar) May 15, 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1947, at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1946 to May 12, 1947 and that I last saw h**** alive on May 9, 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. T. Talley M D M. D. or other

Address: 17 Conduit St. Date signed: 5-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03624

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
144 Market Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 144 Market Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Denver Johnson

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Wellian Johnson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 22, 1862
8. AGE: Years: 84 Months: 6 Days: 1 If less than one day: hrs. min.
9. Birthplace: Delaware
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Charles Moss
13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary Boyle
15. Birthplace: Ireland
16. Informant: Mrs Walter L. Bennett Sr.
Address: 144 Market St. Annpls Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/26/47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John N. Layton & Son
Address: Annapolis, Md.
19. May 26 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1947, at 7:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1947 to May 23, 1947 and that I last saw h[illegible] alive on May 23, 1947

	DURATION
Immediate cause of death: Coronary occlusion	2 days
Due to: Hypertensive Cardio-Vascular Disease	10 yrs
Due to: Myocarditis, Chronic	10 yrs
Other conditions: Senility	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Stanton, M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 5-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

144d

03625

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Dunkirk, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fernice Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Kinsey Jones
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Unknown - 1918

8. AGE: Years	Months	Days	If less than one day
29 ?	?	?	hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 47 (month) (day) (year)
Cemetery or crematory: Mt Hope
Location: Calvert Co
18. Funeral director: Pinkney E Lemle
Address: Prince Frederick Md

19. 5/26 47 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1947 19 47 at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 19 47, to May 21, 19 47 and that I last saw her alive on May 21 19 47

Immediate cause of death	DURATION
Toxemia of Pregnancy	Known to us since 5-16-47
Due to	
Due to	
Other conditions: Toxic Psychosis 640	Known to us since 5-16-47

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. (M. D. or other)
Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Mr. Lindsay

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1866

03626

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Waterberry, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rutland M. Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elizabeth Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1909

8. AGE: Years	Months	Days	If less than one day
37	5	17	..... hrs. ..... min.

9. Birthplace: Rutland, Md. A.A.Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Jones
13. Birthplace: A.A.Co. Md.

MOTHER
14. Maiden name: Anna Snowden
15. Birthplace: A.A.Co. Md.

16. Informant: James Jones
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1947 (month) (day) (year)
Cemetery or crematory: John Wesley Cemetery
Location: Waterberry, Md.
18. Funeral director: Mrs. Annie A. Johnson
Address: Annapolis, Md.

19. May 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1947, at 11:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1947, to May 24 1947 and that I last saw h. alive on May 24 1947

Immediate cause of death	DURATION
Rupture of Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of May 24, 1947
Where did injury occur? Annapolis (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Struck by tree Injured at work? yes

23. SIGNATURE: E. Burkett, Asst. Medical Examiner M. D. or other
Address: Crownsville, Md. Date signed: 5/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03627

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Marley Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Marley Park (Glen Burnie, Md. PO
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Annapolis Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Jordan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jabez Jordan
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): September 6 1899

8. AGE: Years	Months	Days	If less than one day
47	8	21	....hrs. ....min.

9. Birthplace: Glascow, Scotland (Town, county, and state)
10. Usual occupation: House keeper
11. Industry or business: Own Home
FATHER 12. Name: William Hanlet
13. Birthplace: Belfast Ireland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mr. Jabez Jordan
Address: Marley Park, (Glen Burnie, Md.)
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30, 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. May 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947, at 12.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1947, to May 27 1947 and that I last saw h.e. alive on May 26 1947

Immediate cause of death	DURATION
CEREBRAL HEMMORRHAGE	
Due to: MALIGNANT HYPERTENSION 102	
Due to: UNKNOWN	
Other conditions: EARLY DECOMPENSATED HEART	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry F Zaugg MD (M. D. or other)
Address: Glen Burnie, Md. Date signed: 5/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03628

Reg. Dist. No. 28

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 8 mos. 19 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 yrs. 8 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Pasadena,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 38
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Kane - George

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown
--
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): ? 1871

8. AGE: Years	Months	Days	If less than one day
Approximately 70	?	?	-- hrs. -- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER
12. Name: Jerry Kane
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hester Dixon
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: 5/7/47
(month) (day) (year)

Cemetery or crematory: Hospital Cemetery
Location: Crownsville, Maryland

18. Funeral director: Supt Hospital
Address: Crownsville

19. May 7 1947
(Date rec'd by registrar)
E. Dorsey Lowe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1947, at 4:35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 1944, to May 3 1947
and that I last saw him alive on May 3 1947

	DURATION
Immediate cause of death: General Paresis	Known to us since 8-14-44
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Margenten M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 5-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163H

CERTIFICATE OF DEATH

03629

Reg. Diat. No.

M

Correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: 317 Adams St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Adams St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Joseph Kane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Catherine Kane

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1900

8. AGE:

Years	Months	Days	If less than one day
46	6	4	hrs. min.

9. Birthplace: Newark N. J. (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: U.S. Naval Academy

FATHER

12. Name: Patrick J. Kane

13. Birthplace: Ireland

MOTHER

14. Maiden name: Annie C. Liddy

15. Birthplace: Newark, N.J.

16. Informant: William Kane

Address: 89 Shipwright St. Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19 1947 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis Md.

18. Funeral director: John M. Gayley Son

Address: Annapolis Md.

19. May 16, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 , to 19

~~and that I last saw h~~ alive on 19

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Coronary thrombosis	
Due to: incited by inhalation of illuminating gas	
Other conditions: Cancer of larynx — laryngectomy several months ago	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: about 8 hours

Accident, suicide, or homicide: attempted suicide Date of: before body was found

Where did injury occur? at his home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. M.D. or other

Address: Annapolis, Md. Acting M.E. Date signed: May 16, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03630

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 18 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington Co.

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 422 North Jonathan St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clarence A. Lewis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Beatrice Lewis

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): ? 1907

8. AGE: Years	Months	Days	If less than one day
45	?	?	...hrs. ...min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: —

FATHER — 12. Name: George Lewis

13. Birthplace: ?

MOTHER — 14. Maiden name: Elsie ?

15. Birthplace: ?

16. Informant: Hospital Records Crownsville State Hospital, Crownsville, Maryland

Address

17. May 12, 1947 (Burial, cremation, or removal. Which?) Date thereof: Burial (month) (day) (year)

Cemetery or crematory: Rosedale Cemetery

Location: Hagerstown Md

18. Funeral director: William H Downey & John R Waters

Address: 291 Frederick St. Hagerstown Md.

19. May 9 1947 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 19 47, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
General Paresis	Known to us
	since 3-20-47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

03631

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County A. A. Co.

City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. Greenway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM CRAIG LORD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Woodfall Lord

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	29	..... hrs. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Henry E. Lord
13. Birthplace N. Y.

MOTHER
14. Maiden name Mary Alice Hughes
15. Birthplace Tenn.

16. Informant Mrs. Emma Lord

Address Greenway, Glen Burnie

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/47 (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 5/23 19 47 A. W. Hedrick D.R. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 22 1947, at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1946, to MAY 1947 and that I last saw him alive on MAY 21 1947

Immediate cause of death ACUTE CARDIAC FAILURE — DURATION .....

Due to ARTERIOSCLEROSIS — DURATION .....

Due to UNKNOWN. — DURATION .....

Other conditions — DURATION .....

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry F. Lariviere, M.D.
M. D. or other

Address Glen Burnie Date signed 5/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

03632

Reg. Diat. No. 46

1. PLACE OF DEATH:

County A.A.Co.

City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
204 Second Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A.A. Co.

City or town Glen Burnie
(If outside city or town limits, write RURAL and give neareat town)

Street No. 204 Second Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Webster Mackey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 28, 1870

8. AGE: Years	Months	Days	If less than one day
76	8	27	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Veterinarian (Retired)

11. Industry or business

FATHER 12. Name Samuel W. Mackey

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah I Bentley

15. Birthplace Maryland

16. Informant Mrs. Frank B. Ross

Address 204 2nd Ave. S.W. Glenburnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/27.47 (month) (day) (year)

Cemetery or crematory Lorraine

Location Woodlawn, Md.

18. Funeral director Wm. J. Tickner & Sons

Address North & Pa. Aves.

19. May 27 19 47 (Date rec'd by registrar) C. W. Holbrook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 47, at 3;15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DID NOT ATTEND HIM to ..... 19.....

and that I last saw h/im alive on MAY 25 19 47

	DURATION
Immediate cause of death PULMONARY EDEMA	ONE HR
Due to ACUTE CARDIAC FAILURE	TWO HRS
Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE	
Other conditions UNKNOWN	UNKNOWN

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry F. Zaruzna M.D.
M. D. or other

Address Glen Burnie Date signed May 25, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

03633 21

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Truxton Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Truxton Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Anton Markle | 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hester J. Markle
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 17th 1878

8. AGE: Years 69 | Months 2 | Days 27 | If less than one day hrs. min.

9. Birthplace Stanton Va.
(Town, county, and state)

10. Usual occupation Supt. of incenderator
11. Industry or business City of Annapolis Md.

FATHER
12. Name Frank J. Markle
13. Birthplace Stanton Va.

MOTHER
14. Maiden name Francis Smith
15. Birthplace Stanton Va

16. Informant Mrs Hester J. Markle
Address Truxton Heights a a Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1947 (month) (day) (year)
Cemetery or crematory Saint Anne's
Location Annapolis Md
18. Funeral director John M. Taylor & Son
Address Annapolis Md.

19. May 16 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to May 14 1947 and that I last saw h. in alive on May 14 1947

	DURATION
Immediate cause of death Coronary Thrombosis	2 days
Due to Arterio Sclerosis	unknown
Due to	
Other conditions Chronic Angina (angitis) Obesity	2 Years.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other
Address Annapolis Md Date signed 5-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03634

Reg. Diat. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Violetta Rogers Marshall
3.(b) Social Security Number: None

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: James Morris Marshall
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 4 1874
8. AGE: Years: 72 Months: 5 Days: 14 If less than one day: hrs. min.
9. Birthplace: Deale, A.A. Co Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Alexander Rogers
13. Birthplace: Friendship A.A. Co. Md.
MOTHER 14. Maiden name: Violetta Webster
15. Birthplace: New York City
16. Informant: W. Percy Marshall
Address: Deale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1947 (month) (day) (year)
Cemetery or crematory: Deale Cemetery
Location: Deale - Md
18. Funeral director: H.G. Hardesty & Son
Address: Galesville Md
19. May 20 1947 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 18 1947 at 12.15 P.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to May 18 1947
and that I last saw her alive on April 15 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emil H. Wilson, M.D.
M. D. or other
Address: Kathleen, Md. Date signed 5/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03635

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Old Annapolis Blvd.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: near Severna Park
(If outside city or town limits, write RURAL and give neareat town)

Street No.: Old Annapolis Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LUVINIA MATTHEWS

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	col.	widow

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? ? 1867

8. AGE: Years	Months	Days	If less than one day
80			....hrs. ....min.

9. Birthplace: ? Va.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: unknown

13. Birthplace: " "

MOTHER — 14. Maiden name: " "

15. Birthplace: " "

16. Informant: ----

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-27-47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem.

Location: A. A. Co.

16. Funeral director: Annie Johnson

Address: Annapolis, Md.

19. 5-25-47 (Date rec'd by registrar) L. A. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1943, to May 25 1947 and that I last saw her alive on May 19 1947

Immediate cause of death	DURATION
Probable coronary occlusion	sudden
Due to: Arteriosclerosis	indefin.
Due to:	
Other conditions: Hypertension	" "

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. A. Dent M. D.
M. D. or other

Address: Annapolis, Md. Date signed 5-25-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

03636

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: A.A.

County .....

City or town Riva.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Months

Hospital, institution, or street address where death occurred:

Riva. Maryland.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Riva

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Samuel A. Mayhew. Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Gertrude Mayhew

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug 24 I894

8. AGE: Years	Months	Days	If less than one day
52	9	22	..... hrs. ..... min.

9. Birthplace A.A. County (Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

FATHER 12. Name Augustus Mayhew

13. Birthplace A.A. County

MOTHER 14. Maiden name Margaret C. Greenwell

15. Birthplace A.A. County

16. Informant Gertrude Mayhew

Address Riva. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 I947 (month) (day) (year)

Cemetery or crematory St Marys

Location Annapolis. Md.

18. Funeral director B.L.Hopping & Son

Address Ammapolis. Mayyland.

19. May 19 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 47, at 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19 47 to May 16 19 47

and that I last saw h. alive on May 15 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. J. Klaumus, Md M. D. or other

Address 31 South Gate Rd Date signed 5/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03637

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 16 Acton Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 16 Acton Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Howard McCormick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Margaret McCormick

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21, 1878

8. AGE: Years: 69 Months: Days: 10 If less than one day: hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Professor at U.S.N.A.

11. Industry or business

FATHER — 12. Name: Alexander K. McCormick

13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Isabella Howard

15. Birthplace: Washington, D.C.

16. Informant: Mrs. Mary M. McCormick

Address: 16 Acton Place

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-2-47 (month) (day) (year)

Cemetery or crematory: St. Anne's

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. June 2 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 47, at 4:52 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 47 to May 31 19 47 and that I last saw him alive on May 31 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	4 hrs.
Due to: Arterial Hypertension	Several yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Owen Purse, M. D. or other

Address: Annapolis Md. Date signed: 6/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03638

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME

Ossie Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Unknown

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: -

7. Birth date of deceased (mo., day, yr.): ? 1890

8. AGE:	Years	Months	Days	If less than one day
	Approximately 57	?	?	...hrs. ...min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. burial (6-2-47)
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address: Crownsville

19. June 2 1947 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1947, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 20 1947 and that I last saw him alive on May 20 1947

Immediate cause of death: Chronic Intestitial Pneumonia — DURATION: Known to us since 5-3-47

Due to:

Due to:

Other conditions: General Paresis — Known to us since 5-3-47
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 5-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170a

Reg. Dist. No. 03639 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11½ hours
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? Annapolis Hospital 11½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1244 Rockville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Allan Joseph Montouri (Montuori)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1926

8. AGE: Years: 21 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: G. U. School Work D. C.

11. Industry or business: Student

FATHER
12. Name: F. C. Montouri
13. Birthplace: New Jersey U. S. A.

MOTHER
14. Maiden name: Drusilla Kendall
15. Birthplace: Washington D. C.

16. Informant: F. C. Montouri
Address: 1244 Rockville Pike, Rockville, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 20 1947 (month) (day) (year)
Cemetery or crematory: Bethesda Md
Location:

18. Funeral director: W. P. Timanus Jr.
Address: Bethesda Md.

19. May 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I last saw him alive on~~ Postmortem Examination 19.. ~~and that I last saw him alive on~~ May 20 1947

Immediate cause of death	DURATION
Due to: Broken neck	
Due to: Automobile Collision	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 5/19/47
Where did injury occur? Edgewater (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Mayo Road
Means of injury: auto - collision Injured at work? No

23. SIGNATURE: John M. Claffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03640

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 13 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 months 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 592 Baker Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Pearl Moody

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: James Moody
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): ? 1907

8. AGE: Years	Months	Days	If less than one day
44	?	?	... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: —

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.
18. Funeral director: Geo. L. Kilbourn
Address: 1303 Eastern Ave. Balto

19 May 9 1947 E. F. Joyce Local Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1947, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 1947, to May 8 1947
and that I last saw her alive on May 7 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 2-25-47
Due to: Syphilis	Known to us since 2-25-47
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 5-8-47

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03641

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: a. a.

City or town: Tanglewood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: .....

City or town: Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2815 Chesterfield Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME: Howard G. Nicholson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 6th 1886

8. AGE: Years	Months	Days	If less than one day
60	6	18	..... hrs. ..... min.

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U. S. Post Office

FATHER — 12. Name: Thomas G. Nicholson

13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Emma Pilkington

15. Birthplace: Balto. Md.

16. Informant: Geoge B. Nicholson

Address: 2856 Chesterfield Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Parkville Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. May 27 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 19 47, at .....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 46, to 20 May 19 47 and that I last saw him alive on 20 May 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	months
Due to Moderate Hypertension	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William L. Leary M.D. M. D. or other

Address: 3025 Belair Rd Date signed: 5-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03642

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Print or type

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Information is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A.A. Co. Maryland

City or town: Rural Anthyalis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Smith Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louis H. Paine

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: Clara Paine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 19th 1881

8. AGE: Years: 66 Months: 2 Days: 27 If less than one day: ..... hrs. ..... min.

9. Birthplace: Newark N.J.

(Town, county, and state)

10. Usual occupation: Cabinet maker

11. Industry or business

FATHER 12. Name: Charles Paine

FATHER 13. Birthplace: N.J.

MOTHER 14. Maiden name: Henrietta Barcome

MOTHER 15. Birthplace: Mass.

16. Informant: Mrs. James P. Ewart

Address: 129 Smith Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/19/47 (month) (day) (year)

Cemetery or crematory: Edwards Chapel

Location: Parole Maryland

18. Funeral director: John M. Taylor & Son

Address: 147 Clarendon St. Athens, Md.

19. May 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947 at 3.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1947 to May 16 1947 and that I last saw him alive on May 14 1947

Immediate cause of death	DURATION
Ac. Pulmonary Edema	1 hr.
Due to: Chr. myocarditis & arteriosclerosis	yrs.
Due to:	
Other conditions: Cardiac asthma (Include pregnancy within 3 months of death)	yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J. Klemans, Md M. D. or other

Address 31 Southgate Ave Date signed 5/18/47

03643 R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 932

1. PLACE OF DEATH
County: Anne Arundel
City or town: Manhattan Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 hours
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1314 Eutaw St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME William Edward Reilly Sr. | **3.(b) Social Security Number** 216-10-3438

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mamie Krause Reilly
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Mar. 16, 1880

8. AGE: Years: 67 | Months: 2 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: McCormicks Spice Co
11. Industry or business: Retired

FATHER
12. Name: John J. Reilly
13. Birthplace: Va

MOTHER
14. Maiden name: Frances Collins
15. Birthplace: Va

16. Informant: Wm. E. Reilly Jr.
Address: 1314 Eutaw St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville Md.
18. Funeral director: Edgar W. Caulfield & Son
Address: 924 E. Eager St.

19. 6/3 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 47 at 2:15 P. M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examiner
and that I last saw ~~him~~ alive on May 31, 19 47

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to: Chronic Myocarditis	uncertain
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Cattey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5/31/47

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03644

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
1028 West St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1028 West St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Max Schiff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Ethel Schiff
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) May 15 1879

8. AGE: Years	Months	Days	If less than one day
67	11	26	...hrs. ...min.

9. Birthplace Russia
(Town, county, and state)
10. Usual occupation Shoe Repair
11. Industry or business
FATHER 12. Name Abraham Tipoe
13. Birthplace Russia
MOTHER 14. Maiden name Sarah Riva
15. Birthplace Russia
16. Informant Herman Schiff Son
Address 3420 Liberty Heights Baltimore Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12 '47 (month) (day) (year)
Cemetery or crematory Randall Funeral
Location Dumbarton Oak
18. Funeral director B. L. Hopkins & Bro
Address Annapolis Md
19. May 12 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 7:00 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 10 1947 and that I last saw him alive on MAY 10 1947

Immediate cause of death	DURATION
Coronary embolism	8 days
Due to Coronary sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy M.D.
M. D. or other
Address Annapolis, Md Date signed 5/11/47

4507

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52a

Reg. Diat. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Laurel R. F. D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Howard Co.

City or town Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Raymond Webster Schildt

3.(b) Social Security Number 220-12-6161

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Josphine Schildt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30 1882

8. AGE: Years	Months	Days	If less than one day
64	11	24	..... hrs. ..... min.

9. Birthplace Frederick County Maryland (Town, county, and state)

10. Usual occupation Cotton Mill

11. Industry or business

FATHER — 12. Name ~~Unknown~~ Samuel Schildt

13. Birthplace Unknown.

MOTHER — 14. Maiden name Unknown

15. Birthplace

16. Informant John T Schildt

Address Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27 1947 (month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Md.

18. Funeral director Ridgely Dudley

Address 401 Wash ave Laurel Md.

19. May 27 1947 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1947, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to May 24th 1947 and that I last saw h.. alive on May 23rd 1947

Immediate cause of death Carcinoma of Rt. Kidney — DURATION 6 mos.

Due to V

Due to V

Other conditions V

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley M.D.

Address Savage, Md. M. D. or other Date signed 5/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03645

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Baltimore ANNE ARUNDEL

City or town Saunders Range, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) ANNE ARUNDEL

State Maryland County Baltimore

City or town Saunders Range, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME John Schmich

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Maria

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December, 1870

8. AGE: Years	Months	Days	If less than one day
76	5		..... hrs. ..... min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace

MOTHER — 14. Maiden name Unknown

15. Birthplace

16. Informant Maria Hommes

Address Saunders Range

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1947 (month) (day) (year)

Cemetery or crematory Glen Haven Cemetery

Location Baltimore

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul Street

19. May 10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 19 47 at 7:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 19 46 to May 8, 19 47

and that I last saw him alive on May 8, 19 47

Immediate cause of death	DURATION
Arterio sclerotic cardio vascular disease	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry Deitel M.D. M. D. or other

Address 1226 Hanover St. Date signed 5/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03648 S

Reg. Dist. No. 22

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Anne Arundel

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Elizabeth Schultz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife: Henry Schultz

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): May 4 - 1882

8. AGE — Years	Months	Days	If less than one day
65 64	9	22	...hrs. ...min.

9. Birthplace: Severn Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Chase

13. Birthplace: Md

MOTHER — 14. Maiden name: Susan Jackson

15. Birthplace: Md.

16. Informant: Morris Schultz

Address: Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/30/47 (month) (day) (year)

Cemetery or crematory: Friendship

Location: A. A. Co. Md.

18. Funeral director: William Cook Inc

Address: 127 St. Paul St

19. May 28 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 - 47 19... at 3-30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 46 to May 26 19 47 and that I last saw h.e alive on May 23 - 47 19...

Immediate cause of death	DURATION
Acute Coronary Thrombosis	suddy
Due to	
Due to Cardio Vasc. Disease	
Other conditions Essential Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. N. Lippsley M. D. or other

Address: Odenton Md Date Signed: May 26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03646

97

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs. 7 mos. 17 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 20 yrs. 7 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 89 Charles Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Richard Sharps

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): June 7, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	6	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: W. Bowie Sharps
13. Birthplace: Maryland

MOTHER
14. Maiden name: Angelina Harris
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 16, 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: Annapolis, Maryland

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. May 14 1947 (Date rec'd by registrar) E. Joyce Coal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1947, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29 1926, to May 13 1947, and that I last saw him alive on May 13 1947.

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 9-29-26
Due to:	
Due to:	
Other conditions: Senile Psychosis	Known to us since 9-29-26

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of: ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D. M. D. or other
Address: Crownsville, Maryland Date signed: May 14, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

03647

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town FT.G.G.MEADE,MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hpurs 24 min.

Hospital, institution, or street address where death occurred:
Dispensary "A"

How long in hospital or institution? 3 hours 24 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore Co.

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Decatur Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

JEROME PIERCE SHORES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1947

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 24 min.

9. Birthplace Ft.George G.Meade, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Sydney Troy Shores
13. Birthplace Rome, Georgia.

MOTHER
14. Maiden name Edna Jo Rowell
15. Birthplace Rockmart, Georgia

16. Informant Sydney Troy Shores
Address 32 Decatur Road, Baltimore 20, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 15 May 1947 (month) (day) (year)

Cemetery or crematory Post Cemetery

Location Fort George G. Meade, Maryland

18. Funeral director HOWARD N. BLIGHT, JR. Howard N. Blight, Jr.

Address 4914 Belair Road, Baltimore 6, Md.

19. 15 May 1947 (Date rec'd by registrar) RALPH E. CRAYCRAFT, 1st Lt, PC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 1947 at 0154 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2219 13 May 1947, to 0154 14 May 1947

and that I last saw h.i.m. alive on 0154 14 May 47 19

Immediate cause of death	DURATION
Immaturity & Prematurity	
"Asphyxia"	
Due to Immaturity & Prematurity	
Due to "	
Other conditions "	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph N. Carlson 1st Lt MC M. D. or other

Address Ft.George Meade Date signed 15 May 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03649

159

Reg. Dist. No. 27

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: FT.G.G.MEADE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours 4 min.

Hospital, Institution, or street address where death occurred:
Dispensary "A"

How long in hospital or institution? 3 hours 4 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Decatur Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
JUDITH ALLEN SHORES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6.(b) Name of husband or wife:

6.(c) If alive, give age: 13 years

7. Birth date of deceased (mo., day, yr.): May 14, 1947

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. 4 min.

9. Birthplace: FT.G.G.MEADE, MD.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: SYDNEY TROY SHORES
13. Birthplace: ROME, GEORGIA

MOTHER
14. Maiden name: EDNA JO ROWELL
15. Birthplace: ROCKMART, GEORGIA

16. Informant: SYDNEY TROY SHORES
Address: 32 Decatur Road, Baltimore 20, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 15 May 1947 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G. Meade, Maryland

18. Funeral director: HOWARD N. BLIGHT, JR.

Address: 4914 Belair Road, Baltimore 6, Md.

19. 15 May 19 47 (Date rec'd by registrar) RALPH E. RAYCRAFT, 1st Lt, PC (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 14 19 47 at 0134 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2223 hrs 13 May 1947 to 0134 14 May 1947 and that I last saw her alive on 14 May 47 0134 1947

Immediate cause of death	DURATION
Immaturity & Prematurity	
"Asphyxia"	
Due to: Immaturity & Prematurity	
Due to: " "	
Other conditions: " "	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph W. Carlaw 1st Lt MC M. D. or other

Address: Fort George G. Meade Date signed: 15 May 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03650

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Months, 17 days

Hospital, Institution, or street address (If not in hospital): Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 5 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore resident 6 yrs (If outside city or town limits, write RURAL and give nearest town)

Street No. 1727 Druid Hill Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ardia Smith

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: Separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1899

8. AGE: Years: 48 (48) Months: Days: 13 If less than one day: hrs. min.

9. Birthplace: South Carolina (City or town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER 12. Name: Cornileus Smith

13. Birthplace: South Carolina

MOTHER 14. Maiden name: Amanda Means

15. Birthplace: South Carolina

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: Mrs. Louis A. Dawson

Address: Annapolis, Md.

19. May 21 1947 (Date rec'd by registrar) E. Joyce Poore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1946 to May 19 1947

and that I last saw him alive on May 19 1947

	DURATION
Immediate cause of death: Pulmonary embolism with hemorrhagic infarct	2 days
Due to: Syphilitic aortitis	Known to us since Dec. 2, 1946
Due to:	
Other conditions: Paranoid condition (Include pregnancy within 3 months of death)	Known to us since December 2, 1946

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03651

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Catherine & 10 Street
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. 2 Merchant Marine

3.(a) FULL NAME: William Valentine K. Smith

3.(b) Social Security Number: 422-05-8167

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None --
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): August 25. 1905

8. AGE: Years	Months	Days	If less than one day
41	8	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Merchant Seaman
11. Industry or business: Merchant Marine

FATHER
12. Name: Frank B. Smith
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Anna Mary Kasper
15. Birthplace: Baltimore, Md.

16. Informant: John J. Smith
Address: Green Haven, Pasadena, P.O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/26/47 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 6-2347 (Date rec'd by registrar) 19..... L. d. Bleir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947, at 9.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1947, to ..... 19.....
and that I last saw him alive on May 21 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	? months
(patient was moribund when	
Due to: first seen)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. d. Bleir, M. D.
M. D. or other
Address: Pasadena, Md. Date signed: 5-23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 03652

CERTIFICATE OF DEATH

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Sandy Point Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Sandy Point Road (If rural, give LOCATION)

2.(a) If veteran, name war: W

3. (a) FULL NAME: Virginia W. S Snyder.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: Joseph K. Snyder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1859

8. AGE: Years	Months	Days	If less than one day
87	8	28	hrs. min.

8. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Robert H. Shipley

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Louisa Vermilya

15. Birthplace: New York City, N. Y.

16. Informant: Rev. J. Edward Snyder

Address: P. O. Box 1, Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/22/47 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. 5/21 1947 (Date rec'd by registrar) A W Fredrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20th 1947 at 1 21/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1947 to May 20, 1947 and that I last saw h. alive on May 20, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Hypertensive Cardio-Vascular Disease	8 yrs.
Due to Chronic myocarditis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James R. Stratton, M. D. M. D. or other

Address: Annapolis, Md. Date signed: 5/20/47

Reed V.S.
5/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03653

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 29 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 578 W. Biddle Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sadie Maxine Stevens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): [illegible] 1876

8. AGE: Years	Months	Days	If less than one day
71	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business: --

FATHER
12. Name: Westley Limgham
13. Birthplace: Maryland

MOTHER
14. Maiden name: Frank Anna Norton
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 11, 1947 (month) (day) (year)

Cemetery or crematory: John Westley Abington

Location: Harford County, Maryland

18. Funeral director: Mrs. Samuel T. Hemsley

Address: 578 W. Biddle Street, Baltimore

19. May 8 19 47 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1947 19 47 at

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 8, 1946 19 -, to May 7 19 47 and that I last saw her alive on May 7 19 47

Immediate cause of death	DURATION
Coronary Occlusion	1 hour
Due to: Arteriosclerosis	Known to us since 7-8-46
Due to:	
Other conditions: Pulmonary Tuberculosis	Known to us since 3-10-47
Senile Psychosis, Paranoid Type	Known to us since 7-8-46

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D. M. D. or other

Address: Crownsville, Maryland Date signed: 5-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Johnson

Evidence for change of age shown on?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03654

FILE No. G 110 MAY 12 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town (Rural) Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Henry Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife Ada Stewart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug., 27, 1885

8. AGE: Years	Months	Days	If less than one day
~~62~~ 61	8	6	..... hrs. ..... min.

9. Birthplace A.A., Mayo, Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name George Stewart
13. Birthplace Md.

MOTHER
14. Maiden name Matilda Minoka
15. Birthplace Md.

16. Informant Margrett Edley
Address 78 Franklin St. Annapolis, Md.

17. Burial Date thereof May 7, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis, Md.

18. Funeral director J. B. Johnson
Address Annapolis, Md.

19. May 6 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1947, to May 3, 1947
and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Cardiac failure	3 mon.
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. B. Johnson M.D.
M. D. or other
Address 40 Northeast Street Date signed 5/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162b

03655 8

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel.
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Glen Burnie
(If ontside city or town limits, write RURAL and give nearest town)
Street No. Old Guilford Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Annie Gertrude Stinchcomb.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband or wife James B. Stinchcomb. 6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) July 13 - 1861

8. AGE: Years 85 Months 9 Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Seaman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Unk.
15. Birthplace Unk.

16. Informant Mrs. Herbert Stinchcomb.
Address Baltimore, Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof May 11-1947
(month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md
18. Funeral director Pratt & Stricker
Address Pratt & Stricker

19. 5-9 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 5.37 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to May 7 1947
and that I last saw h... alive on 5/7/47 1947

Immediate cause of death Gradual failure of heart and circulatory system — DURATION 1 month.
Due to Myocardial degeneration — 3 months.
Due to Senility
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gustave A. Bouchard M.D.
M. D. or other
Address Glen Burnie, Md Date signed 5/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

8

036567

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 2 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1500 Frederick Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Richard Henry Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown (deceased)

6.(c) If alive, give age: --- – years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years	Months	Days	If less than one day
61	?	?	...hrs. ...min.

9. Birthplace: Wash. D.C.
(Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business: --

FATHER
12. Name: Allen Thomas
13. Birthplace: ?

MOTHER
14. Maiden name: Lidye ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 10, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Western Star

Location: Baltimore, Maryland

18. Funeral director: Katie R. Williams

Address: 322 North Schroeder St. Baltimore, Md.

19. 5-9-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 47, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 19 47, to May 6 19 47

and that I last saw h...im...alive on May 6 19 47

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 4-4-47
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 5-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

03657

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1943

Hospital, Institution, or street address where death occurred:
Civilian Dormitory

How long in hospital or institution? Dead on arrival-Sta Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Dickerson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

JAMES OTHA THOMPSON

3.(b) Social Security Number

220-01-0687

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	SINGLE

6.(b) Name of husband or wife: not married

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPTEMBER 24, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	14	hrs. min.

9. Birthplace: Dickerson, Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: War Department Employee

FATHER
12. Name: Otha Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Beckhard
15. Birthplace: Maryland

16. Informant: Civilian Employee Records
Address: Fort George G. Meade, Maryland

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: 8 May 1947
(month) (day) (year)

Cemetery or crematory: Martinsburg

Location: Martinsburg Maryland

18. Funeral director: Snowden and Davis Funeral Home

Address: Poolesville, Maryland

19. 8 May 19 47 (Date rec'd by registrar) RALPH E. CRAYCRAFT, 1st Lt., PC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 8 19 47 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from -- 19-- to -- 19--
and that I last saw him alive on -- 19--

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? No
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave H. Faubert M.D.
acting Medical Examiner M. D. or other

Address: Federal Bureau of Inv. Washington, D.C. Date signed: 5/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Marley Park, P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred: Annapolis Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Marley Park Glen Burnie P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Annapolis Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Harrison Triggs.
3.(b) Social Security Number

4. Sex M.
5. Color or race W.
6.(a) Single, married, widowed, or divorced married
6.(b) Name of ~~husband~~ or wife Maryann Brethauer
6.(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) June 14 - 1893

8. AGE: Years	Months	Days	If less than one day
53	11	6	....hrs. ....min.

9. Birthplace Martinsburg, W. Virginia
(Town, county, and state)
10. Usual occupation ~~Stone mason~~ Tavern Keeper
11. Industry or business Barowner.
FATHER 12. Name Charles Triggs
13. Birthplace West Virginia
MOTHER 14. Maiden name Emma V. Hughes.
15. Birthplace West Virginia
16. Informant Mrs. S. H. Triggs (wife)
Address Marley Park, P.O. Glen Burnie
17. Burial Date thereof May 23rd 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie Md
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.
19. 5/21 1947 Marie Allen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 10.40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h— alive on ....19....

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Pauker MD
M. D. or other
Address Glen Burnie Md Date signed 5/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03659

Reg. Diat. No.

P

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne A.

City or town Arnold

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — yrs.

Hospital, Institution, or street address where death occurred:

Pines on Severn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne Arundel

City or town Pines on the Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war N

3.(a) FULL NAME Lillian Mary Ireton

3.(b) Social Security Number N

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm. Ireton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30. 1879

8. AGE:

Years	Months	Days	If less than one day
68	11	15	..... hrs. ..... min.

9. Birthplace Germantown Pa.

(Town, county, and state)

10. Usual occupation None -

11. Industry or business

FATHER 12. Name Bernard Heisemann

13. Birthplace Germany

MOTHER 14. Maiden name Caroline Emrich

15. Birthplace Pa

16. Informant Wm. J. Ireton

Address Pines on the Severn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/47 (month) (day) (year)

Cemetery or crematory Mt. Cuyamaca

Location Philadelphia Pa

18. Funeral director Wilson & Son Inc

Address 1217 Pine St

19. 5-16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1938 to May 15 1947

and that I last saw her alive on May 15 1947

Immediate cause of death	OURATION
Cardio-Vascular Disease	5 days
Due to	
Due to	
Other conditions	
Hypertension	10 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr MD

M. D. or other

Address Linthicum Date signed 5-15-47

03660

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County ~~xxxxxxxxx~~ Anne Arundel

City or town ~~xxxxxxx~~ Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Jan. 30, 1915

Hospital, Institution, or street address where death occurred:

since January 30, 1915, Crownsville State

How long in hospital or Institution? 32years, 3 months, 20days Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No. ?

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Turpin - Maggie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Negro	married

6.(b) Name of husband or ~~wife~~ William S. Turpin

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) unknown 1870

8. AGE: Years	Months	Days	If less than one day
about 77	?	?	..... hrs. ..... min.

9. Birthplace unknown (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital records

Address Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-47 (month) (day) (year)

Cemetery or crematory Dead Island

Location Dead Island

18. Funeral director James H. Stewart

Address Salisbury Md

19. May 23 1947 (Date rec'd by registrar) E. Joyce Corse Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 5 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30, 1915 to May 19 1947

and that I last saw her alive on May 19 1947

	DURATION
Immediate cause of death Myodegeneratio cordis	Known to us since
	January 30, 1915
Due to	
Due to	
Other conditions Manic depressive psychosis manic type	Known to us since
(Include pregnancy within 3 months of death)	January 30, 1915

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob Morgenstern M.D. M. D. or other

Address Crownsville, Maryland Date signed 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

03661

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County a a.

City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Birth.

Hospital, Institution, or street address where death occurred:
Old Annapolis Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 N. Annapolis Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME David Lee Waldman —

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March. 13-1947-

8. AGE: Years	Months	Days	If less than one day
0	1	20	..... hrs. ..... min.

9. Birthplace Baltimore Md. (City)
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Carl Waldman —

13. Birthplace Baltimore - Md.

MOTHER 14. Maiden name Agnes Hoops

15. Birthplace Belair.

16. Informant Carl Waldman

Address Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1947. (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas W. Driscoll

Address Glen Burnie, Md.

19. May 5 1947 (Date rec'd by registrar) Mr Calla Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 3 1947, at 7 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 13 1947 to May 3 1947 and that I last saw h— alive on May 3 1947

	DURATION
Immediate cause of death Influenza —	2 weeks
Due to Had been sick for 2 weeks & died while alone in bed after eating — Apparently	
Due to	
Other conditions Experienced some mild —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball J M.D. M. D. or other

Address Linthicum Date signed 5-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63b

03662

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? 4 days
Hospital, Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills (Post office)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural (above)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emil M. WEBER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Edith Weber
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): December 21, 1892

8. AGE: Years	Months	Days	If less than one day
54	5	10	hrs. min.

9. Birthplace: Belleville, Ill
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Weber
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Keveloch
15. Birthplace: France

16. Informant: Mrs Edith Weber
Address: Gambrills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4, 1947 (month) (day) (year)
Cemetery or crematory: All. Hallows
Location: Davidsonville, Maryland

18. Funeral director: Ben L. Hopping & Son
Address: 170-172 West St. Annapolis, Md.

19. June 3, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1947 at 11:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1942, to May 31 1947 and that I last saw him alive on May 31 1947

Immediate cause of death	DURATION
Acute dilatation of heart	1 hr
Due to rheumatic heart disease	20 yrs.
Due to	
Other conditions Arteriosclerosis with pneumonia - chronic passive congestion & ascites.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Boorsuck MD
M. D. or other
Address: Annapolis MD Date signed: 6/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03663

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 8 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 3 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 N. Bradford Street
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Willis - Herbert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Unknown (1904)

8. AGE: 43 Years	Months	Days	If less than one day
Approximately	?	?	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: Elga Willis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ida Stewart
15. Birthplace: Virginia

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: May 14-1947 (mo.) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: Brooklyn Md

18. Funeral director: Elroy O. Wilson

Address: 1000 Bentley Ave

19. (Date rec'd by registrar) May 13 19 47 C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1947 19 47 at 8:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 19 47 to May 10 19 47 and that I last saw him alive on May 10 19 47

Immediate cause of death	DURATION
General Paresis	Known to us since 2-2-47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 4-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CROWNSVILLE STATE HOSPITAL
CROWNSVILLE, MD.

DR. ROBERT P. WINTERODE, SUPT.

TELEPHONE, SOUTH SHORE 2751

May 10,1947

To Whom it May Concern:

The name on the accompanying Certificate of Death is according to Hospital Records. The name of deceased is believed to be Howard Willis, which is the name used on the second admission to this Hospital. The first time deceased was admitted to this Hospital however, it was under the name of Herbert Willis. In order to keep Hospital records straight, both names are recorded on Certificate of Death.

Jacob Morgenstern M.D.

Jacob Morgenstern, M. D.
Clinical Director

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03664

FILM No. G 11 JUN 27 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Arnold a. a Co Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Arnold

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katherine H. Wilson

3. (b) Social Security Number

4. Sex: Female

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Samuel T. Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 15th 1869

8. AGE: Years 78/77 | Months 4 | Days 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Jacob Hartmann

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Depton

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs Margaret Madley

Address: Arnold A.A.Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Near Baltimore Pike Hwy

18. Funeral director: John M. Taylor Sons

Address: Annapolis Md.

19. May 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947 at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947 to May 29 1947 and that I last saw h[illegible] alive on May 27 1947

Immediate cause of death: Possibly Undulant Fever — DURATION: 2 mos.

Due to: (This patient was [illegible] examined and treated at Mercy Hospital

Due to: by the Pediatrics + Internal Medicine staffs with no conclusive diagnosis)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE M. F. Kleinman, M.D. M. D. or other

Address 31 South Gay St Date signed 5/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83b

CERTIFICATE OF DEATH

03665

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, Institution, or street address where death occurred:
58 Larkins St. Annapolis

How long in hospital or institution? ××××××××××××××××××××

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 58 Larkins St.
(If rural, give LOCATION)

2.(a) If veteran, name war ××××××××××××××××××××

3.(a) FULL NAME: Martha Wilson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: ××××××××××××××××××××

6.(c) If alive, give age ××× years

7. Birth date of deceased (mo., day, yr.): March 12, ? 1877

8. AGE: Years	Months	Days	If less than one day
70(?)		?	hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and stete)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Katel Jones
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Wallace
15. Birthplace: Anne Arundel

16. Informant: Mrs Woodward
Address: 58 Larkins St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1947 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemteery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1947, at 12.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1947 to May 1 1947 and that I last saw h- alive on April 25 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	2 hrs.
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice D. Klaware, Md
M. D. or other

Address: 31 South Calvert Date signed: 5/3/47

03666

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 921 Jackson
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Filmore Washington Windsor. Sr

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mattie Windsor
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): April 26, 1856.

8. AGE: Years	Months	Days	If less than one day
91	0	5	hrs. min.

9. Birthplace: near Cambridge, Dorchester Co., Md.
(Town, county, and state)
10. Usual occupation: retired Carpenter
11. Industry or business: building (general)

FATHER
12. Name: John William Windsor
13. Birthplace: Dorchester Co., Maryland

MOTHER
14. Maiden name: Nancy E. Wroten
15. Birthplace: Dorchester Co., Maryland.

16. Informant: Mrs. Mattie Windsor
Address: 921 Jackson St, Eastport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 '47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Annapolis Md
18. Funeral director: A. F. Hopkins & Co
Address: Annapolis Md

19. May 2 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

35

20. DATE OF DEATH: May 1, 1947 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24, 1947 to Apr. 26, 1947 and that I last saw h. l. m. alive on April 26, 1947

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: General Arteriosclerosis,	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D.
M. D. or other
Address: Annapolis, Md Date signed 5/1/47.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03667

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 11 mos. 15 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 yrs. 11 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: --
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elva Wisher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: --
7. Birth date of deceased (mo., day, yr.): Oct. 25, 1925

8. AGE: Years	Months	Days	If less than one day
21	6	16	--hrs. --min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business: --

FATHER
12. Name: James Wisher, deceased
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jennie M. Wright, deceased
15. Birthplace: Unknown

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 15, 1947 (month) (day) (year)
Cemetery or crematory: Denton
Location: Denton, Maryland

18. Funeral director: J. Virgil Moore J. Virgil Moore
Address: Denton, Maryland

19. May 12 1947 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947, at 6:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1944, to May 11 1947 and that I last saw her alive on May 11 1947

Immediate cause of death: Tuberculosis of Lungs — DURATION: Known to us since 5-30-46
Due to:
Due to:
Other conditions: Schizophrenia - Catatonic type — Known to us since 5-26-44
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquardt M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 5-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

03668

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Green Haven, P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Green Haven, P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 11 Fleet

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Willard P. Youngbar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2 1947

8. AGE: Years | Months: 2 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Ferndale, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: Henry Youngbar

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Lois Hackerman

MOTHER — 15. Birthplace: New York.

16. Informant: Mrs. Henry Youngbar (mother)

Address: Green Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12-1947 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Park Cem.

Location: Gov. Ritchie Highway

18. Funeral director: Milton Schilling

Address: 3914 Hanover St - 25 -

19. 5/10 (Date rec'd by registrar) 19 47 Bert Cat. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947, at 5:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to 19—

and that I last saw h— alive on 19—

	DURATION
Immediate cause of death: Asphyxia —	Sudden.
Baby slept in bed	
Due to: with Mattress & other	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5/9/47

Where did injury occur? Green Haven (City or town) A. A. (County) Md. (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave H. Pauke M.D. deputy medical examiner M. D. or other

Address: Odenton, Md. Date signed 5/9/47